TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Final Rule
LSA Document #12-279(F)

DIGEST

Amends 405 IAC 1-12-1, 405 IAC 1-12-3, 405 IAC 1-12-11, and 405 IAC 1-12-26 to revise rate-setting criteria for nonstate-owned intermediate care facilities for the mentally retarded and community residential facilities for the developmentally disabled. Amends 405 IAC 1-14.6-1 through 405 IAC 1-14.6-4, 405 IAC 1-14.6-7, 405 IAC 1-14.6-9 through 405 IAC 1-14.6-12, 405 IAC 1-14.6-14, 405 IAC 1-14.6-18, and 405 IAC 1-14.6-22 to revise rate-setting criteria for nursing facilities. Amends 405 IAC 1-14.6-24 to revise the nursing facility provider quality assessment fee. Repeals 405 IAC 1-14.6-23 and 405 IAC 1-14.6-25. Effective 30 days after filing with the Publisher.

405 IAC 1-12-1; 405 IAC 1-12-3; 405 IAC 1-12-11; 405 IAC 1-12-26; 405 IAC 1-14.6-1; 405 IAC 1-14.6-2; 405 IAC 1-14.6-3; 405 IAC 1-14.6-4; 405 IAC 1-14.6-7; 405 IAC 1-14.6-9; 405 IAC 1-14.6-10; 405 IAC 1-14.6-11; 405 IAC 1-14.6-12; 405 IAC 1-14.6-14; 405 IAC 1-14.6-18; 405 IAC 1-14.6-22; 405 IAC 1-14.6-23; 405 IAC 1-14.6-24; 405 IAC 1-14.6-25

SECTION 1. 405 IAC 1-12-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-1 Policy; scope

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 6-8.1-10-1; IC 12-13-7-3; IC 12-15-13-4

Sec. 1. (a) This rule sets forth procedures for payment for services rendered to Medicaid recipients by duly certified intermediate care facilities for the mentally retarded (ICF/MR), with the exception of those facilities operated by the state, and community residential facilities for the developmentally disabled (CRF/DD). Reimbursement for facilities operated by the state is governed by 405 IAC 1-17. All payments referred to within this rule for the provider groups and levels of care are contingent upon the following:

(1) Proper and current certification.

(2) Compliance with applicable state and federal statutes and regulations.

(b) The procedures described in this rule set forth methods of reimbursement that promote quality of care, efficiency, economy, and consistency. These procedures recognize level and quality of care, establish effective accountability over Medicaid expenditures, provide for a regular review mechanism for rate changes, and compensate providers for reasonable, allowable costs. The system of payment outlined in this rule is a prospective system. Cost limitations are contained in this rule which establish parameters regarding the allowability of costs and define reasonable allowable costs.

(c) Retroactive repayment will be required by providers when an audit verifies overpayment due to discounting, intentional misrepresentation, billing or payment errors, or misstatement of historical financial or historical statistical data which caused a higher rate than would have been allowed had the data been true and accurate. Upon discovery that a provider has received overpayment of a Medicaid claim from the office, the provider must complete the appropriate Medicaid billing adjustment form and reimburse the office for the amount of the overpayment, or the office shall make a retroactive payment adjustment, as appropriate.

(d) The office may implement Medicaid rates and recover overpayments from previous rate reimbursements, either through deductions of future payments or otherwise, without awaiting the outcome of the administrative appeal process, **in accordance with IC 12-15-13-4(e).**

(e) Providers must pay interest on all overpayments, **consistent with IC 12-15-13-4.** The interest charge shall not exceed the percentage set out in ~~IC 12-15-13-3(f)(1).~~ **IC 6-8.1-10-1(c).** The interest shall accrue from the date of the overpayment to the provider and shall apply to the net outstanding overpayment during the periods in which such overpayment exists.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-1; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2314; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 718; readopted filed

Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA)

SECTION 2. 405 IAC 1-12-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-3 Accounting records; retention schedule; audit trail; accrual basis; segregation of accounts by nature of business and by location

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 3. (a) The basis of accounting used under this rule is a comprehensive basis of accounting other than generally accepted accounting principles. ~~However, generally accepted accounting principles shall be followed in the preparation and presentation of all financial reports and all reports detailing proposed change of provider status transactions, unless otherwise prescribed by this rule.~~ **Costs must be reported in the cost report in accordance with the following authorities, in the hierarchical order listed:**

(1) Costs must be reported in accordance with the specific provisions as set forth in this rule, any financial report instructions, provider bulletins, and any other policy communications.

(2) Costs must be reported in conformance with cost finding principles published in the Medicare Provider Reimbursement Manual, CMS 15-1.

(3) Costs must be reported in conformance with generally accepted accounting principles.

(b) Each provider must maintain financial records for a period of three (3) years after the date of submission of financial reports to the office. The accrual basis of accounting shall be used in all data submitted to the office except for government operated providers that are otherwise required by law to use a cash system. The provider's accounting records must establish an audit trail from those records to the financial reports submitted to the office.

(c) ~~In the event that~~ **When** a field audit indicates that the provider's records are inadequate to support data submitted to the office **or the additional requested documentation is not provided pursuant to the auditor's request,** and the auditor is unable to complete the audit, ~~and issue an opinion, the provider shall be given, in writing, a list of the deficiencies and allowed sixty (60) days from the date of receipt of this notice to correct the deficiencies. In the event the deficiencies are not corrected within the sixty (60) day period, the office shall not grant any rate increase to the provider until the cited deficiencies are corrected and notice is sent to the office by the provider. However, the office may:~~

~~(1) make appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records;~~

~~(2) document such adjustments in a finalized exception report; and~~

~~(3) incorporate such adjustments in prospective rate calculations under section 1(d) of this rule.~~ **the following actions shall be taken:**

(1) The auditor shall give a written notice listing all of the deficiencies in documentation.

(2) The provider will be allowed thirty (30) days from the date of the notice to provide the documentation and correct the deficiencies.

(3) Not later than thirty (30) days from the date of the notice described in subdivision (1), the provider may seek one (1) thirty (30) day extension to respond to the notice and shall describe the reason(s) the extension is necessary.

~~(d) Each provider shall submit, upon request by the office, confirmation that all deficiencies and adjustments noted in the field audit final written report have been corrected and are not present in the current period annual financial report. However, if deficiencies and adjustments are not corrected, the office may make appropriate adjustments to current and subsequent cost reports of the provider.~~

(d) In the event that the deficiencies in documentation are not corrected within the time limit specified in subsection (c), the following actions shall be taken:

(1) The rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the date the response was due.

(2) The ten percent (10%) reduction shall remain in place until the first day of the month following the receipt of a complete response.

(3) If no response described in subdivision (2) is received, this reduction expires one (1) year after the

effective date specified in subdivision (1).
(4) No rate increases will be allowed until the first day of the month following the receipt of the response and requested documentation, or the expiration of the reduction.
(5) No reimbursement for the difference between the rate that would have otherwise been in place and the reduced rate is recoverable by the provider.

(e) In the event that the documentation submitted is inadequate or incomplete, the following additional actions shall be taken:
(1) Appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records shall be made.
(2) The audit contractor shall document such adjustments in a finalized exception report.
(3) The rate setting contractor shall incorporate such adjustments in the prospective rate calculations under section 1(d) of this rule.

~~(e)~~ **(f)** If a provider has business enterprises other than those reimbursed by Medicaid under this rule, the revenues, expenses, and statistical and financial records for such enterprises shall be clearly identifiable from the records of the operations reimbursed by Medicaid. If a field audit establishes that records are not maintained so as to clearly identify Medicaid information, none of the commingled costs shall be recognized as Medicaid allowable costs and the provider's rate shall be adjusted to reflect the disallowance effective as of the date of the most recent rate change.

~~(f)~~ **(g)** When multiple facilities or operations are owned by a single entity with a central office, the central office records shall be maintained as a separate set of records with costs and revenues separately identified and appropriately allocated to individual facilities. Each central office entity shall file an annual or historical financial report coincidental with the time period for any type of rate review for any individual facility that receives any central office allocation. Allocation of central office costs shall be reasonable, conform to GAAP, and be consistent between years. Any change of central office allocation bases must be approved by the office prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the office at least ninety (90) days prior to the reporting period to which the change applies. Such costs are allowable only to the extent that the central office is providing services related to patient or resident care and the provider can demonstrate that the central office costs improved efficiency, economy, and quality of recipient care. The burden of demonstrating that costs are patient or resident related lies with the provider.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-3; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2316; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA)

SECTION 3. 405 IAC 1-12-11 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-11 Allowable costs; services provided by parties related to provider

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 11. (a) Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control ~~may~~ **must** be included in the allowable cost in the unit of service of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased ~~elsewhere in~~ **as** an arm's-length transaction **in an open competitive market.**

(b) Common ownership exists when an individual, individuals, or any legal entity possesses ownership or equity of at least five percent (5%) in the provider as well as the institution or organization serving the provider. An individual is considered to own the interest of immediate family for the determination of percentage of ownership. The following persons are considered immediate family:
(1) Husband and wife.
(2) Natural parent, child, and sibling.
(3) Adopted child and adoptive parent.
(4) Stepparent, stepchild, stepsister, and stepbrother.
(5) Father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, ~~and~~ daughter-in-law, **stepson-in-law,**

and stepdaughter-in-law.
(6) Grandparent and grandchild.

(c) Control exists where an individual or an organization has the power, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised.

(d) Transactions between related parties are not considered to have arisen through arm's-length negotiations. Costs applicable to services, facilities, and supplies furnished to a provider by related parties shall not exceed the lower of the cost to the related party or the price of comparable services, facilities, or supplies purchased ~~elsewhere~~ **as an arm's-length transaction in an open competitive market.** An exception to this subsection may be granted by the office if requested in writing by the provider before the rate effective date of the review to which the exception is to apply. **The provider's request shall include a comprehensive representation that every condition in subsection (e) has been met. This representation shall include, but not be limited to, the percentage of business the provider transacts with related and nonrelated parties based upon revenue. When requested by the office, the provider shall submit documentation, such as invoices, standard charge master listings, and remittances, to substantiate the provider's charges for services, facilities, or supplies to related and nonrelated parties.**

(e) The office shall grant an exception when a related organization meets all of the following conditions:
(1) The supplying organization is a bona fide separate organization **whose services, facilities, and supplies are made available to the public in an open competitive market.**
(2) A sufficient part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier in common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization. **Transactions with residents of facilities that are owned, operated, or managed by the provider or organizations related to the provider shall not be considered a business activity for purposes of meeting this requirement.**
(3) The services, supplies, or facilities are those which commonly are obtained by institutions, such as the provider, from other organizations and are not a basic element of patient or resident care ordinarily furnished directly to patients or residents by such institutions.
(4) The **organization actually furnishes such services, facilities, or supplies to other nonrelated party organizations, and the** charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

(f) The related-party exception shall be granted for any period of time, up to the maximum period of two (2) years.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-11; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2321; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA)

SECTION 4. 405 IAC 1-12-26 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-26 Administrative reconsideration; appeal

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 4-21.5-3; IC 12-13-7-3

Sec. 26. (a) The Medicaid rate-setting contractor shall notify each provider of the provider's rate and allowable cost determinations after they have been computed. If the provider disagrees with the rate or allowable cost determinations, the provider ~~must~~ **may** request an administrative reconsideration by the Medicaid rate-setting contractor. Such reconsideration request shall be in writing and shall contain specific issues to be reconsidered and the rationale for the provider's position. **The provider must request administrative reconsideration before filing an appeal. Only issues raised by the provider during the administrative reconsideration may be subsequently raised in an appeal.** The request shall be signed by the provider or the authorized representative of the provider and must be received by the contractor ~~within~~ **not later than** forty-five (45) days after release of the rate or allowable cost determinations as computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid rate-setting contractor shall evaluate the data. After review, the Medicaid rate-setting contractor may amend the rate, amend the challenged procedure or allowable cost

determination, or affirm the original decision. The Medicaid rate-setting contractor shall thereafter notify the provider of its final decision in writing, ~~within~~ **not later than** forty-five (45) days ~~of~~ **from** the Medicaid rate-setting contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the rate-setting contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies as set out in subsection (c).

(b) If the provider disagrees with ~~a~~ **the preliminary recalculated Medicaid** rate or allowable cost redetermination resulting from ~~an~~ **a financial** audit adjustment or ~~a~~ reportable condition ~~affecting a rate,~~ the provider ~~must~~ **may** request an administrative reconsideration from the Medicaid audit contractor. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. **The provider must request administrative reconsideration before filing an appeal. Only issues raised by the provider during the administrative reconsideration may be subsequently raised in an appeal.** The request shall be signed by the provider or the authorized representative of the provider and must be received by the Medicaid audit contractor ~~within~~ **not later than** forty-five (45) days after release of the **preliminary recalculated Medicaid** rate or allowable cost determinations as computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid audit contractor shall evaluate the data. After review, the Medicaid audit contractor may amend the audit adjustment or reportable condition or affirm the original adjustment or reportable condition. The Medicaid audit contractor shall thereafter notify the provider of its final decision in writing ~~within~~ **not later than** forty-five (45) days ~~of~~ **from** the Medicaid audit contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the audit contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (c).

(c) After completion of the reconsideration procedure under subsection (a) or (b), the provider may initiate an appeal under ~~IC 4-21.5.~~ **IC 4-21.5-3. The request for an appeal must be signed by the provider.**

(d) The office may take action to implement Medicaid rates without awaiting the outcome of the administrative process, in accordance with section 1(d) of this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-26; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2331; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 730; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA)

SECTION 5. 405 IAC 1-14.6-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-1 Policy; scope

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 6-8.1-10-1; IC 12-13-7-3; IC 12-15-13-4; IC 24-4.6-1-101

Sec. 1. (a) This rule sets forth procedures for payment for services rendered to Medicaid recipients by duly certified nursing facilities (NF). All payments referred to within this rule are contingent upon the following:
(1) Proper and current certification.
(2) Compliance with applicable state and federal statutes and regulations.

(b) The procedures described in this rule set forth methods of reimbursement that promote quality of care, access, efficiency, economy, and consistency. These procedures recognize level and quality of care, access, establish effective accountability over Medicaid expenditures, provide for a regular review mechanism for rate changes, and, only to the extent the state is required to by state law, compensate providers for reasonable, allowable costs which must be incurred by efficiently and economically operated facilities. The system of payment outlined in this rule is a prospective system. Cost limitations are contained in this rule that establish parameters regarding the allowability of costs and define reasonable allowable costs.

(c) Retroactive payment or repayment will be required when an audit verifies an underpayment or overpayment due to intentional misrepresentation, billing or payment errors, or misstatement of historical financial or historical statistical data, or resident assessment data which caused a lower or higher rate than would have been allowed had the data been true and accurate. Upon discovery that a provider has received overpayment of a Medicaid claim from the office, the provider must complete the appropriate Medicaid billing adjustment form and

reimburse the office for the amount of the overpayment, or the office shall make a retroactive payment adjustment, as appropriate.

(d) The office may implement Medicaid rates and recover overpayments from previous rate reimbursements, either through deductions of future payments or otherwise, without awaiting the outcome of the administrative appeal process, in accordance with IC 12-15-13-4(e).

(e) Providers must pay interest on all overpayments, consistent with IC 12-15-13-4. The interest charge shall not exceed the percentage set out in IC 6-8.1-10-1(c). The interest shall:

(1) accrue from the date of the overpayment to the provider; and

(2) apply to the net outstanding overpayment during the periods in which such overpayment exists.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-1; filed Aug 12, 1998, 2:27 p.m.: 22 IR 69, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA)

SECTION 6. 405 IAC 1-14.6-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-2 Definitions

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 2. (a) The definitions in this section apply throughout this rule.

(b) "Administrative component" means the portion of the Medicaid rate that shall reimburse providers for allowable administrative services and supplies, including prorated employee benefits based on salaries and wages. Administrative services and supplies include the following:

(1) Administrator and co-administrators, owners' compensation (including director's fees) for patient-related services.

(2) Services and supplies of a home office that are:

(A) allowable and patient-related; and

(B) appropriately allocated to the nursing facility.

(3) Office and clerical staff.

(4) Legal and accounting fees.

(5) Advertising.

(6) **All staff** travel **and mileage.**

(7) Telephone.

(8) License dues and subscriptions.

(9) **All** office supplies **used for any purpose, including repairs and maintenance charges and service agreements for copiers and other office equipment.**

(10) Working capital interest.

(11) State gross receipts taxes.

(12) Utilization review costs.

(13) Liability insurance.

(14) Management and other consultant fees.

(15) Qualified mental retardation professional (QMRP).

(16) Educational seminars for administrative staff.

(17) Support and license fees for all general and administrative computer software and hardware such as accounting or other data processing activities.

(c) "Allowable per patient day cost" means a ratio between allowable variable cost and patient days using each provider's actual occupancy from the most recently completed desk reviewed annual financial report, plus a ratio between allowable fixed costs and patient days using the greater of:

(1) the minimum occupancy requirements as contained in this rule; or

(2) each provider's actual occupancy rate from the most recently completed desk reviewed annual financial report.

(d) "Allowed profit add-on payment" means the portion of a facility's tentative profit add-on payment that, except as may be limited by application of the overall rate ceiling as defined in this rule, shall be included in the facility's Medicaid rate, and is ~~determined~~ based on the facility's:

(1) nursing home report card score ~~based on~~ **using** the latest published data as of the end of each state fiscal year **for periods through June 30, 2013; or**

(2) the total quality score for periods beginning July 1, 2013.

(e) "Annual financial report" refers to a presentation of financial data, including appropriate supplemental data and accompanying notes, derived from accounting records and intended to communicate the provider's economic resources or obligations at a point in time, or changes therein for a period of time in compliance with the reporting requirements of this rule.

(f) "Average allowable cost of the median patient day" means the allowable per patient day cost (including any applicable inflation adjustment) of the median patient day from all providers when ranked in numerical order based on average allowable cost. The average allowable variable cost (including any applicable inflation adjustment) shall be computed on a statewide basis using each provider's actual occupancy from the most recently completed desk reviewed annual financial report. The average allowable fixed costs (including any applicable inflation adjustment) shall be computed on a statewide basis using an occupancy rate equal to the greater of:

(1) the minimum occupancy requirements as contained in this rule; or

(2) each provider's actual occupancy rate from the most recently completed desk reviewed annual financial report.

The average allowable cost of the median patient day shall be maintained by the office with revisions made four (4) times per year effective January 1, April 1, July 1, and October 1.

(g) "Average historical cost of property of the median bed" means the allowable patient-related property per bed for facilities that are not acquired through an operating lease arrangement, when ranked in numerical order based on the allowable patient-related historical property cost per bed that shall be updated each calendar quarter. Property shall be considered allowable if it satisfies the conditions of section 14(a) of this rule.

(h) "Calendar quarter" means a three (3) month period beginning January 1, April 1, July 1, or October 1.

(i) "Capital component" means the portion of the Medicaid rate that shall reimburse providers for the use of allowable capital-related items. Such capital-related items include the following:

(1) The fair rental value allowance.

(2) Property taxes.

(3) Property insurance.

(j) "Case mix index" or "CMI" means a numerical value score that describes the relative resource use for each resident within the groups under the resource utilization group (RUG-III) classification system prescribed by the office based on an assessment of each resident. The facility CMI shall be based on the resident CMI, calculated on a facility-average, time-weighted basis for the following:

(1) Medicaid residents.

(2) All residents.

(k) "Children's nursing facility" means a nursing facility that, as of January 1, 2009, has:

(1) fifteen percent (15%) or more of its residents who are under the chronological age of twenty-one (21) years; and

(2) received written approval from the office to be designated as a children's nursing facility.

(l) "Cost center" means a cost category delineated by cost reporting forms prescribed by the office.

(m) "Delinquent MDS resident assessment" means an assessment that is greater than one hundred thirteen (113) days old, as measured by the date defined by CMS for determining delinquency or an assessment that is not completed within the time prescribed in the guidelines for use in determining the time-weighted CMI under section 9(e) of this rule. This determination is made on the fifteenth day of the second month following the end of

a calendar quarter.

(n) "Desk review" means a review and application of these regulations to a provider submitted annual financial report including accompanying notes and supplemental information.

(o) "Direct care component" means the portion of the Medicaid rate that shall reimburse providers for allowable direct patient care services and supplies, including prorated employee benefits based on salaries and wages. Direct care services and supplies include all of the following:

(1) Nursing and nursing aide services.
(2) Nurse consulting services.
(3) Pharmacy consultants.
(4) Medical director services.
(5) Nurse aide training.
(6) Medical supplies.
(7) Oxygen.
(8) Medical records costs.
(9) Rental costs for low air loss mattresses, pressure support surfaces, and oxygen concentrators. Rental cost for these items are limited to one dollar and fifty cents ($1.50) per resident day.
(10) Support and license fees for software utilized exclusively in hands-on resident care support, such as MDS assessment software and medical records software.
(11) Replacement dentures for Medicaid residents provided by the facility that exceed state Medicaid plan limitations for dentures.
(12) Legend and nonlegend sterile water used for any purpose.
(13) Educational seminars for direct care staff.

(p) "Fair rental value allowance" means a methodology for reimbursing nursing facilities for the use of allowable facilities and equipment, based on establishing a rental valuation on a per bed basis of such facilities and equipment, and a rental rate.

(q) "Field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts and resident assessment data and its supporting documentation by auditors.

(r) "Fixed costs" means the portion of each rate component that shall be subjected to the minimum occupancy requirements as contained in this rule. The following percentages shall be multiplied by total allowable costs to determine allowable fixed costs for each rate component:

Rate Component	Fixed Cost Percentage
Direct Care	25%
Indirect Care	37%
Administrative	84%
Capital	100%

(s) "Forms prescribed by the office" means either of the following:
(1) Cost reporting forms provided by the office.
(2) Substitute forms that have received prior written approval by the office.

(t) "General line personnel" means management personnel above the department head level who perform a policymaking or supervisory function impacting directly on the operation of the facility.

(u) "Generally accepted accounting principles" or "GAAP" means those accounting principles as established by the American Institute of Certified Public Accountants.

(v) "Incomplete MDS resident assessment" means an assessment that is not printed by the nursing facility provider upon request by the office or its contractor.

(w) "Indirect care component" means the portion of the Medicaid rate that shall reimburse providers for allowable indirect patient care services and supplies, including prorated employee benefits based on salaries and wages. Indirect care services and supplies include the following:

(1) Dietary services and supplies.
(2) Raw food.
(3) Patient laundry services and supplies.
(4) Patient housekeeping services and supplies.
(5) Plant operations services and supplies.
(6) Utilities.
(7) Social services.
(8) Activities supplies and services.
(9) Recreational supplies and services.
(10) Repairs and maintenance.
(11) Cable or satellite television throughout the nursing facility, including residents' rooms.
(12) Pets, pet supplies and maintenance, and veterinary expenses.
(13) Educational seminars for indirect care staff.
(14) All costs related to nonambulance travel and transportation of residents.

(x) "Medical and nonmedical supplies and equipment" includes those items generally required to assure adequate medical care and personal hygiene of patients.

(y) "Minimum data set" or "MDS" means a core set of screening and assessment elements, including common definitions and coding categories, that form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in the Medicaid program. The items in the MDS standardize communication about resident problems, strengths, and conditions within facilities, between facilities, and between facilities and outside agencies. Version 2.0 (9/2000) is the most current form to the minimum data set (MDS 2.0). The Indiana system will employ the MDS 2.0 or subsequent revisions as approved by the Centers for Medicare and Medicaid Services (CMS).

(z) "Normalized allowable cost" means total allowable direct patient care costs for each facility divided by that facility's average CMI for all residents.

(aa) "Nursing home report card score" means a numerical score developed and published by the Indiana state department of health (ISDH) that quantifies each facility's key survey results.

(bb) "Office" means the office of Medicaid policy and planning.

(cc) "Ordinary patient-related costs" means costs of allowable services and supplies that are necessary in delivery of patient care by similar providers within the state.

(dd) "Patient/recipient care" means those Medicaid program services delivered to a Medicaid enrolled recipient by a certified Medicaid provider.

(ee) "Reasonable allowable costs" means the price a prudent, cost-conscious buyer would pay a willing seller for goods or services in an arm's-length transaction, not to exceed the limitations set out in this rule.

(ff) "Related party/organization" means that the provider:
(1) is associated or affiliated with; or
(2) has the ability to control or be controlled by;
the organization furnishing the service, facilities, or supplies, whether or not such control is actually exercised.

(gg) "RUG-III resident classification system" means the resource utilization group used to classify residents. When a resident classifies into more than one (1) RUG III group, the RUG III group with the greatest CMI will be utilized to calculate the facility-average CMI for all residents and facility-average CMI for Medicaid residents.

(hh) A nursing facility with a "special care unit (SCU) for Alzheimer's disease or dementia" means a nursing

facility that meets all of the following:

(1) Has a locked, secure, segregated unit or provides a special program or special unit for residents with Alzheimer's disease, related disorders, or dementia.

(2) The facility advertises, markets, or promotes the health facility as providing Alzheimer's care services or dementia care services, or both.

(3) The nursing facility has a designated director for the Alzheimer's and dementia special care unit, who satisfies all of the following conditions:

(A) Became the director of the SCU prior to ~~April 1, 1997,~~ **August 21, 2004,** or has earned a degree from an educational institution in a health care, mental health, or social service profession, or is a licensed health facility administrator.

(B) Has a minimum of one (1) year work experience with dementia or Alzheimer's, or both, residents within the past five (5) years.

(C) Completed a minimum of twelve (12) hours of dementia specific training within three (3) months of initial employment and has continued to obtain six (6) hours annually of dementia-specific training thereafter to:

(i) meet the needs or preferences, or both, of cognitively impaired residents; and

(ii) gain understanding of the current standards of care for residents with dementia.

(D) Performs the following duties:

(i) Oversees the operations of the unit.

(ii) Ensures personnel assigned to the unit receive required in-service training.

(iii) Ensures the care provided to Alzheimer's and dementia care unit residents is consistent with in-service training, current Alzheimer's and dementia care practices, and regulatory standards.

(ii) "Tentative profit add-on payment" means the profit add-on payment calculated under this rule before considering a facility's nursing home report card score.

(jj) "Therapy component" means the portion of each facility's direct costs for therapy services, including any employee benefits prorated based on total salaries and wages, rendered to Medicaid residents that are not reimbursed by other payors, as determined by this rule.

(kk) "Total quality score" means the sum of the quality points awarded to each nursing facility for all eight (8) quality measures as determined in section 7(n)(1) through 7(n)(8) of this rule.

~~(kk)~~ **(ll)** "Unit of service" means all patient care included in the established per diem rate required for the care of an inpatient for one (1) day (twenty-four (24) hours).

~~(ll)~~ **(mm)** "Unsupported MDS resident assessment" means an assessment where one (1) or more data items that are required to classify a resident pursuant to the RUG-III resident classification system:

(1) are not supported according to the MDS supporting documentation guidelines as set forth in 405 IAC 1-15; and

(2) result in the assessment being classified into a different RUG-III category.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-2; filed Aug 12, 1998, 2:27 p.m.: 22 IR 69, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2238; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2462; filed Oct 10, 2002, 10:47 a.m.: 26 IR 707; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3869; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2975; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 12, 2009, 4:01 p.m.: 20091209-IR-405090215FRA; filed Nov 1, 2010, 11:37 a.m.: 20101201-IR-405100183FRA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA)

SECTION 7. 405 IAC 1-14.6-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-3 Accounting records; retention schedule; audit trail; accrual basis; segregation of accounts by nature of business and by location

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 3. (a) **The basis of accounting under this rule is a comprehensive basis of accounting other than** generally accepted accounting principles. ~~shall be followed in the preparation and presentation of all financial~~

~~reports and all reports detailing change of provider transactions unless otherwise prescribed by this rule.~~ **Costs must be reported in the cost report in accordance with the following authorities, in the hierarchal order listed:**

(1) Costs must be reported in accordance with the specific provisions as set forth in this rule, any financial report instructions, provider bulletins, and any other policy communications.

(2) Costs must be reported in conformance with cost finding principles published in the Medicare Provider Reimbursement Manual, CMS 15-1.

(3) Costs must be reported in conformance with generally accepted accounting principles.

(b) Each provider must maintain financial records for a period of three (3) years after the date of submission of financial reports to the office. The accrual basis of accounting shall be used in all data submitted to the office except for government operated providers that are otherwise required by law to use a cash system. The provider's accounting records must establish an audit trail from those records to the financial reports submitted to the office.

(c) ~~In the event that~~ **When** a field audit indicates that the provider's records are inadequate to support data submitted to the office, **or when the additional requested documentation is not provided pursuant to the auditor's request,** and the auditor is unable to complete the audit, ~~and issue an opinion, the provider shall be given, in writing, a list of the deficiencies and allowed sixty (60) days from the date of receipt of this notice to correct the deficiencies. In the event the deficiencies are not corrected within the sixty (60) day period, the office shall not grant any rate increase to the provider until the cited deficiencies are corrected and notice is sent to the office by the provider. However, the office may:~~

~~(1) make appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records;~~

~~(2) document such adjustments in a finalized exception report; and~~

~~(3) incorporate such adjustments in prospective rate calculations under subsection (d).~~ **the following actions shall be taken:**

(1) The auditor shall give a written notice listing all of the deficiencies in documentation.

(2) The provider will be allowed thirty (30) days from the date of the notice to provide the documentation and correct the deficiencies.

(3) Not later than thirty (30) days from the date of the notice described in subdivision (1), the provider may seek one (1) thirty (30) day extension to respond to the notice and shall describe the reason or reasons the extension is necessary.

~~(d) Each provider shall submit confirmation that all deficiencies and adjustments noted in the field audit final written report have been corrected and are not present in the current period annual financial report. However, if deficiencies and adjustments are not corrected, the office may make appropriate adjustments to current and subsequent cost reports of the provider.~~

(d) In the event that the deficiencies in documentation are not corrected within the time limit specified in subsection (c), the following actions shall be taken:

(1) The rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the date the response was due.

(2) The ten percent (10%) reduction shall remain in place until the first day of the month following the office's receipt of a complete response.

(3) If no response described in subdivision (2) is received, this reduction expires one (1) year after the effective date specified in subdivision (1).

(4) No rate increases will be allowed until the first day of the calendar quarter following the office's receipt of the response and requested documentation, or the expiration of the reduction.

(5) No reimbursement for the difference between the rate that would have otherwise been in place and the reduced rate is recoverable by the provider.

(e) In the event that the documentation submitted is inadequate or incomplete, the following additional actions shall be taken:

(1) Appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records shall be made.

(2) The audit contractor shall document such adjustments in a finalized exception report.

(3) The rate setting contractor shall incorporate such adjustments in the prospective rate calculations under section 1(d) of this rule.

~~(e)~~ **(f)** If a provider has business enterprises or activities other than those reimbursed by Medicaid under this rule, the revenues, expenses, and statistical and financial records for such enterprises or activities shall be clearly identifiable from the records of the operations reimbursed by Medicaid. If a field ~~or desk~~ audit **or desk review** establishes that records are not maintained so as to clearly identify Medicaid information, none of the commingled costs shall be recognized as Medicaid allowable costs.

~~(f)~~ **(g)** When multiple facilities or operations are owned by a single entity with a central office, the central office records shall be maintained as a separate set of records with costs and revenues separately identified and appropriately allocated to individual facilities. Each central office entity shall file an annual financial report coincidental with the time period for any individual facility that receives any central office allocation. Allocation of central office costs shall be reasonable, conform to GAAP, and be consistent between years. Any change of central office allocation bases must be approved by the office prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the office at least ninety (90) days prior to the reporting period to which the change applies. Such costs are allowable only to the extent that the central office is providing services related to patient care and the provider can demonstrate that the central office costs ~~improve~~ **improved** efficiency, economy, and quality of recipient care. The burden of demonstrating that costs are patient-related lies with the provider.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-3; filed Aug 12, 1998, 2:27 p.m.: 22 IR 71, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2465; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA)

SECTION 8. 405 IAC 1-14.6-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-4 Financial report to office; annual schedule; prescribed form; extensions; penalty for untimely filing

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 4. (a) Each provider shall submit an annual financial report to the office not later than the last day of the fifth calendar month after the close of the provider's reporting year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within sixty (60) days after the initial certification of a provider. This option:

(1) may be exercised only one (1) time by a provider; and

(2) must coincide with the fiscal year end for Medicare cost reporting purposes.

If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report. Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a written copy of their Medicare cost report that covers their most recently completed historical reporting period.

(b) The first annual Financial Report for Nursing Facilities for a provider that has undergone a change of provider ownership or control through an arm's length transaction between unrelated parties shall coincide with that provider's first fiscal year end in which the provider has a minimum of six (6) full calendar months of actual historical financial data. The provider shall submit their first annual financial report to the office not later than the last day of the fifth calendar month after the close of the provider's reporting year or thirty (30) days following notification that the change of provider ownership has been reviewed by the office or its contractor. Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a written copy of their Medicare cost report that covers their most recently completed historical reporting period.

(c) The provider's annual financial report shall be **completed in accordance with applicable instructions and** submitted using forms prescribed by the office. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following as a minimum:

(1) Patient census data.

(2) Statistical data.

(3) Ownership and related party information.

(4) Statement of all expenses and all income, excluding non-Medicaid routine income.

(5) Detail of fixed assets and patient-related interest bearing debt.
(6) Complete balance sheet data.
(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period. Private pay charges shall be the lowest usual and ordinary charge.
(8) Certification by the provider that:
(A) the data are true, accurate, and related to patient care; and
(B) expenses not related to patient care have been clearly identified.
(9) Certification by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer by the provider and as such are true and accurate to the best of the preparer's knowledge.
(10) A copy of the working trial balance that was used in the preparation of their submitted Medicaid cost report.
(11) A copy of the crosswalk document used to prepare the Medicaid cost report that contains an audit trail documenting the cost report schedule, line number, and column where each general ledger account is reported on the cost report.
(12) Any other documents deemed necessary by the office to accomplish full financial disclosure of the provider's operation.
~~(13) Schedule for SCU for Alzheimer's disease or dementia.~~

(d) An extension of the five (5) month filing period shall not be granted.

(e) Failure to submit an annual financial report or Medicare cost report by nursing facilities that are certified to provide Medicare-covered skilled nursing facility services within the time limit required shall result in the following actions:
(1) No rate review shall be accepted or acted upon by the office until the delinquent reports are received.
(2) When an annual financial report or Medicare cost report by nursing facilities that are certified to provide Medicare-covered skilled nursing facility services is more than one (1) calendar month past due, the rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the seventh month following the provider's fiscal year end and shall so remain until the first day of the month after the delinquent annual financial report or Medicare cost report (if required) is received by the office. No rate adjustments will be allowed until the first day of the calendar quarter following receipt of the delinquent annual financial report. Reimbursement lost because of the penalty cannot be recovered by the provider. If the:
(A) Medicare filing deadline for submitting the Medicare cost report is delayed by the Medicare fiscal intermediary; and
(B) provider fails to submit their Medicare cost report to the office on or before the due date as extended by the Medicare fiscal intermediary;
then the ten percent (10%) rate reduction for untimely filing to the office as referenced herein shall become effective on the first day of the month following the due date as extended by the Medicare fiscal intermediary.

(f) Nursing facilities are required to electronically transmit MDS resident assessment information in a complete, accurate, and timely manner. MDS resident assessment information for a calendar quarter must be transmitted by the fifteenth day of the second month following the end of that calendar quarter. An extension of the electronic MDS assessment transmission due date may be granted by the office to a new operation attempting to submit MDS assessments for the first time if the:
(1) new operation is not currently enrolled or submitting MDS assessments under the Medicare program; and
(2) provider can substantiate to the office circumstances that preclude timely electronic transmission.

(g) Residents discharged prior to completing an initial assessment that is not preceded by a Medicare assessment or a regularly scheduled assessment will be classified in one (1) of the following RUG-III classifications:
(1) SSB classification for residents discharged before completing an initial assessment where the reason for discharge was death or a transfer to a hospital.
(2) CC1 classification for residents discharged before completing an initial assessment where the reason for discharge was other than death or a transfer to a hospital.
(3) The classification from their immediately preceding assessment for residents discharged before completing a regularly scheduled assessment.

(h) If the office or its contractor determines that a nursing facility has incomplete MDS resident assessments, then, for purposes of determining the facility's CMI, the assessment or assessments shall be assigned the CMI

associated with the RUG-III group "BC1 - Unclassifiable".

(i) If the office or its contractor determines that a nursing facility has delinquent MDS resident assessments, then, for purposes of determining the facility's CMI, the assessment or assessments shall be assigned the CMI associated with the RUG-III group "BC2 - Delinquent".

(j) If the office or its contractor determines due to an MDS field audit that a nursing facility has unsupported MDS resident assessments, then the following procedures shall be followed in applying any corrective remedy:

(1) The office or its contractor:

(A) shall audit a sample of MDS resident assessments; and

(B) determine the percent of assessments in the sample that are unsupported.

(2) If the percent of assessments in the initial sample that are unsupported is greater than twenty percent (20%), the office or its contractor shall expand to a larger sample of residents assessments. If the percent of assessments in the initial sample that are unsupported is equal to or less than twenty percent (20%):

(A) the office or its contractor shall conclude the field portion of the MDS audit; and

(B) no corrective remedy shall be applied.

(3) For nursing facilities with MDS audits performed on the initial and expanded sample of residents assessments, the office or its contractor will determine the percent of all assessments audited that are unsupported.

(4) If the percent of assessments for the initial and expanded sample of all assessment audited residents that are unsupported is greater than twenty percent (20%), a corrective remedy shall apply, which shall be calculated as follows:

(A) The administrative component portion of the Medicaid rate in effect for the calendar quarter following completion of the MDS audit shall be reduced by the percentage as shown in the following table:

MDS Field Audit for Which Corrective Remedy Is Applied	Administrative Component Corrective Remedy Percent
First MDS field audit	15%
Second consecutive MDS field audit	20%
Third consecutive MDS field audit	30%
Fourth or more consecutive MDS field audit or audits	50%

(B) In the event a corrective remedy is imposed, for purposes of determining the average allowable cost of the median patient day for the administrative component, there shall be no adjustment made by the office or its contractor to the provider's allowable administrative costs.

(C) Reimbursement lost as a result of any corrective remedies shall not be recoverable by the provider.

(5) If the percent of assessments for the initial and expanded sample of all assessments audited that are unsupported is equal to or less than twenty percent (20%):

(A) the office or its contractor shall conclude the MDS audit; and

(B) no corrective remedy shall apply.

(k) Based on findings from the MDS audit ~~beginning on the effective date of this rule,~~ the office or its contractor shall make adjustments or revisions to all MDS data items that are required to classify a resident pursuant to the RUG-III resident classification system that are not supported according to the MDS supporting documentation guidelines as set forth in 405 IAC 1-15. Such adjustments or revisions to MDS data transmitted by the nursing facility will be made in order to reflect the resident's highest functioning level that is supported according to the MDS supporting documentation guidelines as set forth in 405 IAC 1-15. The resident assessment will then be used to reclassify the resident pursuant to the RUG-III resident classification system by incorporating any adjustments or revisions made by the office or its contractor.

(l) Upon conclusion of an MDS audit, the office or its contractor shall recalculate the facility's CMI. If the recalculated CMI results in a change to the established Medicaid rate:

(1) the rate shall be recalculated; and

(2) any payment adjustment shall be made.

(m) The Employee Turnover report (Schedule X) and the Special Care Unit report (Schedule Z) shall be completed by all providers based on the calendar year (January 1 through December 31) reporting period. Schedules X and Z must be submitted to the office not later than March 31 following the end of each calendar year. Reports submitted after March 31 will not be considered in the determination of the subsequent annual rate review.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-4; filed Aug 12, 1998, 2:27 p.m.: 22 IR 72, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2240; errata filed Jun 21, 1999, 12:25 p.m.: 22 IR 3419; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2465; filed Oct 10, 2002, 10:47 a.m.: 26 IR 709; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 12, 2009, 4:01 p.m.: 20091209-IR-405090215FRA; filed Nov 1, 2010, 11:37 a.m.: 20101201-IR-405100183FRA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA)

SECTION 9. 405 IAC 1-14.6-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-7 Inflation adjustment; minimum occupancy level; case mix indices

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-13-6

Sec. 7. (a) For purposes of determining the average allowable cost of the median patient day and a provider's annual rate review, each provider's cost from the most recent completed year will be adjusted for inflation by the office using the methodology in this subsection. All allowable costs of the provider, except for mortgage interest on facilities and equipment, depreciation on facilities and equipment, rent or lease costs for facilities and equipment, and working capital interest shall be adjusted for inflation using the CMS Nursing Home without Capital Market Basket index as published by DRI/WEFA. The inflation adjustment shall apply from the midpoint of the annual financial report period to the midpoint prescribed as follows:

Effective Date	Midpoint Quarter
January 1, Year 1	July 1, Year 1
April 1, Year 1	October 1, Year 1
July 1, Year 1	January 1, Year 2
October 1, Year 1	April 1, Year 2

(b) Notwithstanding subsection (a), beginning July 1, ~~2011,~~ **2014,** the inflation adjustment determined as prescribed in subsection (a) shall be reduced by an inflation reduction factor equal to three and three-tenths percent (3.3%). The resulting inflation adjustment shall not be less than zero (0). Any reduction or elimination of the inflation reduction factor shall be made effective no earlier than permitted under IC 12-15-13-6(a).

(c) In determining prospective allowable costs for a new provider that has undergone a change of provider ownership or control through an arm's-length transaction between unrelated parties, when the first fiscal year end following the change of provider ownership or control is less than six (6) full calendar months, the previous provider's most recently completed annual financial report used to establish a Medicaid rate for the previous provider shall be utilized to calculate the new provider's first annual rate review. The inflation adjustment for the new provider's first annual rate review shall be applied from the midpoint of the previous provider's most recently completed annual financial report period to the midpoint prescribed under subsection (a).

(d) Allowable fixed costs per patient day for direct care, indirect care, and administrative costs shall be computed based on the following minimum occupancy levels:
(1) For nursing facilities with less than fifty-one (51) beds, an occupancy rate equal to the greater of eighty-five percent (85%), or the provider's actual occupancy rate from the most recently completed historical period.
(2) For nursing facilities with greater than fifty (50) beds, an occupancy rate equal to the greater of ninety percent (90%) or the provider's actual occupancy rate from the most recently completed historical period.

(e) Notwithstanding subsection (d), the office or its contractor shall reestablish a provider's Medicaid rate effective on the first day of the quarter following the date that the conditions specified in this subsection are met, by applying all provisions of this rule, except for the applicable minimum occupancy requirement described in subsection (d), if both of the following conditions can be established to the satisfaction of the office:
(1) The provider demonstrates that its current resident census has:
(A) increased to the applicable minimum occupancy level described in subsection (d), or greater since the facility's fiscal year end of the most recently completed and desk reviewed cost report utilizing total nursing facility licensed beds as of the most recently completed desk reviewed cost report period; and
(B) remained at such level for not fewer than ninety (90) days.

(2) The provider demonstrates that its resident census has:
(A) increased by a minimum of fifteen percent (15%) since the facility's fiscal year end of the most recently completed and desk reviewed cost report; and
(B) remained at such level for not fewer than ninety (90) days.

(f) Allowable fixed costs per patient day for capital-related costs shall be computed based on an occupancy rate equal to the greater of ninety-five percent (95%) or the provider's actual occupancy rate from the most recently completed historical period.

(g) Except as provided for in subsection (h), the CMIs contained in this subsection shall be used for purposes of determining each resident's CMI used to calculate the facility-average CMI for all residents and the facility-average CMI for Medicaid residents.

RUG-III Group	RUG-III Code	CMI Table
Rehabilitation	RAD	2.02
Rehabilitation	RAC	1.69
Rehabilitation	RAB	1.50
Rehabilitation	RAA	1.24
Extensive Services	SE3	2.69
Extensive Services	SE2	2.23
Extensive Services	SE1	1.85
Special Care	SSC	1.75
Special Care	SSB	1.60
Special Care	SSA	1.51
Clinically Complex	CC2	1.33
Clinically Complex	CC1	1.27
Clinically Complex	CB2	1.14
Clinically Complex	CB1	1.07
Clinically Complex	CA2	0.95
Clinically Complex	CA1	0.87
Impaired Cognition	IB2	0.93
Impaired Cognition	IB1	0.82
Impaired Cognition	IA2	0.68
Impaired Cognition	IA1	0.62
Behavior Problems	BB2	0.89
Behavior Problems	BB1	0.77
Behavior Problems	BA2	0.67
Behavior Problems	BA1	0.54
Reduced Physical Functions	PE2	1.06
Reduced Physical Functions	PE1	0.96
Reduced Physical Functions	PD2	0.97
Reduced Physical Functions	PD1	0.87
Reduced Physical Functions	PC2	0.83
Reduced Physical Functions	PC1	0.76
Reduced Physical Functions	PB2	0.73
Reduced Physical Functions	PB1	0.66
Reduced Physical Functions	PA2	0.56
Reduced Physical Functions	PA1	0.50
Unclassifiable	BC1	0.48
Delinquent	BC2	0.48

(h) In place of the CMIs contained in subsection (g), ~~beginning on the effective date of this rule amendment and continuing thereafter,~~ the CMIs contained in this subsection shall be used for purposes of determining the

facility-average CMI for Medicaid residents that meet all the following conditions:

(1) The resident classifies into one (1) of the following RUG-III groups:

(A) PB2.

(B) PB1.

(C) PA2.

(D) PA1.

(2) The resident has a cognitive status indicated by a brief interview of mental status score (BIMS) greater than or equal to ten (10) or, if there is not a BIMS score, then a cognitive performance score (CPS) of:

(A) zero (0) – Intact;

(B) one (1) – Borderline Intact; or

(C) two (2) – Mild Impairment.

(3) Based on an assessment of the resident's continence control as reported on the MDS, the resident is not experiencing occasional, frequent, or complete incontinence control.

(4) The resident has not been admitted to any Medicaid-certified nursing facility before ~~the effective date of this rule amendment.~~ **January 1, 2010.**

(5) If the office or its contractor determines that a nursing facility has delinquent MDS resident assessments that are assigned a CMI in accordance with this subsection, then, for purposes of determining the facility's average CMI for Medicaid residents, the assessment or assessments shall be assigned ninety-six percent (96%) of the CMI associated with the RUG-III group determined in this subsection.

RUG-III Group	RUG-III Code	~~CMIs effective for the period following the effective date of this rule amendment~~		
		~~The first calendar quarter through the fourth calendar quarter~~	**CMI Table** ~~The fifth calendar quarter through the eighth calendar quarter~~ **Effective 10/1/2011, through 12/31/2011**	**CMI Table** ~~The ninth calendar quarter and thereafter~~ **Effective 1/1/2012, and thereafter**
Reduced Physical Functions	PB2	~~0.48~~	0.41	0.30
Reduced Physical Functions	PB1	~~0.44~~	0.38	0.28
Reduced Physical Functions	PA2	~~0.38~~	0.32	0.24
Reduced Physical Functions	PA1	~~0.33~~	0.28	0.21

(i) The office or its contractor shall provide each nursing facility with the following:

(1) A preliminary CMI report that will:

(A) serve as confirmation of the MDS assessments transmitted by the nursing facility; and

(B) provide an opportunity for the nursing facility to correct and transmit any missing or incorrect MDS assessments.

The preliminary report will be provided by the twenty-fifth day of the first month following the end of a calendar quarter.

(2) Final CMI reports utilizing MDS assessments received by the fifteenth day of the second month following the end of a calendar quarter. These assessments received by the fifteenth day of the second month following the end of a calendar quarter will be utilized to establish the facility-average CMI and facility-average CMI for Medicaid residents utilized in establishing the nursing facility's Medicaid rate.

(j) The office ~~may~~ **will** increase Medicaid reimbursement to nursing facilities that provide inpatient services to more than eight (8) ventilator-dependent residents. Additional reimbursement shall be made to the facilities at a rate of eleven dollars and fifty cents ($11.50) per Medicaid resident day. The additional reimbursement shall:

(1) be effective on the day the nursing facility provides inpatient services to more than eight (8) ventilator-dependent residents; and

(2) remain in effect until the first day of the calendar quarter following the date the nursing facility provides inpatient services to eight (8) or fewer ventilator-dependent residents.

(k) Beginning ~~July 1, 2003,~~ **October 1, 2011,** through June 30, ~~2011,~~ **2013,** the office will increase Medicaid reimbursement to nursing facilities to encourage improved quality of care to residents based on the nursing home report card score. For purposes of determining the nursing home report card score rate add-on ~~effective with this rule amendment and each July 1 thereafter,~~ the office or its contractor shall determine each nursing facility's report card score based on the latest published data as of the end of ~~each~~ **the** state fiscal year. The nursing home report card score rate add-on shall be computed as described in the following table:

Nursing Home Report Card Score	Nursing Home Report Card Score Rate Add-On
0 – 82	~~$5.75~~ **$14.30**
83 – 265	~~$5.75~~ **$14.30** – ((Nursing Home Report Card Score – 82) × ~~$0.03125)~~ **$0.0777)**
266 and above	$0

Facilities that did not have a nursing home report card score published as of the most recently completed state fiscal year may receive a per patient day rate add-on equal to two dollars ($2).

(l) Beginning effective July 1, 2003, through June 30, ~~2011,~~ **2014,** the office will increase Medicaid reimbursement to nursing facilities that provide specialized care to residents with Alzheimer's disease or dementia, as demonstrated by resident assessment data as of ~~March~~ **December** 31 of each year. **Medicaid Alzheimer and dementia residents shall be determined to be in the SCU based on an exact match of room numbers reported on Schedule Z with the room numbers reported on resident assessments and tracking forms. Resident assessments and tracking forms with room numbers that are not an exact match to the room numbers reported on Schedule Z will be excluded in calculating the number of Medicaid Alzheimer and dementia resident days in their SCU.** The additional Medicaid reimbursement shall equal twelve dollars ($12) per Medicaid **Alzheimer and dementia** resident day in their SCU. Only facilities that meet the definition for a SCU for Alzheimer's disease or dementia shall be eligible to receive the additional reimbursement. The additional Medicaid reimbursement shall be effective July 1 of the next state fiscal year.

~~(m) Nursing facilities that satisfy each of the four (4) conditions listed in this subsection shall qualify for a capital component rate add-on:~~

~~(1) Twenty-five percent (25%) or more of its residents as of December 31, 2006, were under the chronological age of twenty-one (21) years of age.~~

~~(2) According to the last health facility survey conducted by Indiana state department of health on or before December 31, 2006, the facility was not in compliance with 42 CFR 483.70(d)(1)(i).~~

~~(3) The facility bedrooms accommodate no more than four (4) residents.~~

~~(4) The facility bedrooms measure at least eighty (80) square feet per resident in multiple resident bedrooms and at least one hundred (100) square feet in single resident rooms.~~

(m) Beginning July 1, 2013, through June 30, 2014, the office will increase Medicaid reimbursement to nursing facilities to encourage improved quality of care to residents based on each facility's total quality score. For purposes of determining the nursing facility quality rate add-on, each facility's total quality score will be determined annually. Each nursing facility's quality rate add-on shall be determined as follows:

Nursing Facility Total Quality Score	**Nursing Facility Quality Rate Add-On**
0 – 18	**$0**
19 – 83	**$14.30 – ((84 - Nursing Facility Total Quality Score) × 0.216667)**
84 – 100	**$14.30**

~~(n) The capital component rate add-on referenced in subsection (m) shall be calculated by dividing the qualifying facility's debt service associated with financing acquired exclusively to fund any capital costs incurred by the provider to come into compliance with 42 CFR 483.70(d)(1)(i), divided by total patient days from the facility's latest completed annual financial report. For purposes of this provision, debt service shall mean the total annual interest and principal payments required to be paid on any such financing arrangement or arrangements. The capital component rate add-on shall be determined upon qualification for the add-on shall be determined following the provider's demonstration to the office of qualification for this provision, and shall become effective on the date the provider successfully completes the health facility survey of any new beds as conducted by the state department of health. The capital component rate add-on shall not be updated annually. Refinancing shall be recognized only when the interest rate is less than the original financing. The capital component rate add-on shall continue to apply until the associated financing has been fully paid.~~

(n) Each nursing facility shall be awarded no more than one hundred (100) quality points as **determined by the following eight (8) quality measures:**

(1) Nursing home report card score. The office or its contractor shall determine each nursing facility's quality points using the report card score published by the Indiana state department of health. Each nursing facility shall be awarded not more than seventy-five (75) quality points based on its nursing

home report card score. Each nursing facility's quality points shall be determined using each nursing facility's most recently published report card score as of June 30, 2013, and each June 30 thereafter. Each nursing facility's quality points under this subdivision shall be determined as follows:

Nursing Home Report Card Scores	Quality Points Awarded
0 – 82	75
83 – 265	Proportional quality points awarded as follows: 75 – [(facility report card score – 82) × 0.407609]]
266 and above	0

Facilities that did not have a nursing home report card score published as of June 30, 2013, or each June 30 thereafter, shall be awarded the statewide average quality points for this measure.

(2) Normalized weighted average nursing hours per resident day. The office or its contractor shall determine each nursing facility's normalized weighted average nursing hours per resident day using data from its annual financial report. Nursing hours per resident day include nurse staff hours for RN, LPN, nursing assistants, and other nursing personnel categories. Nursing hours per resident day for each nurse staff category shall be weighted by the facility-specific CNA average wage rates, and normalized by dividing each facility's weighted average nursing hours per resident day by the facility's case mix index for all residents. Each nursing facility shall be awarded not more than ten (10) quality points based on the normalized weighted average nursing hours per resident day. Quality points shall be determined using each nursing facility's most recently completed annual financial report as of June 30, 2013, and each June 30 thereafter. Each nursing facility's quality points under this subdivision shall be determined as follows:

Normalized Weighted Average Nursing Hours Per Resident Day	Quality Points Awarded
Less than or equal to 3.315	0
Greater than 3.315 and less than 4.401	Proportional quality points awarded as follows: 10 – [(4.401 – facility's normalized weighted average nursing hours per resident day) × 9.208103]
Equal to or greater than 4.401	10

Facilities that are a new operation and did not have a normalized weighted average nursing hours per resident day from the most recently completed annual financial report as of June 30, 2013, or each June 30 thereafter, shall be awarded the statewide average quality points for this measure.

(3) RN/LPN retention rate. The office or its contractor shall determine each nursing facility's RN/LPN retention rate using data from its Schedule X. Each nursing facility shall be awarded no more than three (3) quality points based on the facility's RN/LPN retention rate. Quality points shall be determined using each nursing facility's most recently completed Schedule X as of March 31, 2013, and each March 31 thereafter. Each nursing facility's quality points under this subdivision shall be determined as follows:

Nursing Facility's RN/LPN Retention Rates	Quality Points Awarded
Less than or equal to 58.3%	0
Greater than 58.3% and less than 83.3%	Proportional quality points awarded as follows: 3 – [(83.3% - facility's annual RN/LPN retention rate) × 12]
Equal to or greater than 83.3%	3

Facilities that are a new operation and did not have RNs/LPNs for the entire calendar year preceding March 31, 2013, or each March 31 thereafter, shall be awarded the statewide average quality points for this measure. Facilities that did not submit a Schedule X as of March 31 shall receive zero (0) quality points for this measure.

(4) CNA retention rate. The office or its contractor shall determine each nursing facility's CNA retention rate using data from its Schedule X. Each nursing facility shall be awarded no more than three (3) quality points based on the facility's CNA retention rate. Quality points shall be determined using each nursing facility's most recently completed Schedule X as of March 31, 2013, and each March 31 thereafter. Each nursing facility's quality points under this subdivision shall be determined as follows:

Nursing Facility's CNA Retention Rates	Quality Points Awarded
Less than or equal to 49.5%	0

Greater than 49.5% and less than 76.0%	**Proportional quality points awarded as follows: 3 – [(76.0% – facility's annual CNA retention rate) × 11.320755]**
Equal to or greater than 76.0%	**3**

Facilities that are a new operation and did not have CNAs for the entire calendar year preceding March 31, 2013, or each March 31 thereafter, shall be awarded the statewide average quality points for this measure. Facilities that did not submit a Schedule X as of March 31 shall receive zero (0) quality points for this measure.

(5) RN/LPN turnover rate. The office or its contractor shall determine each nursing facility's RN/LPN turnover rate using data from its Schedule X. Each nursing facility shall be awarded not more than one (1) quality point based on the facility's RN/LPN turnover rate. Quality points shall be determined using each nursing facility's most recently completed Schedule X as of March 31, 2013, and each March 31 thereafter. Each nursing facility's quality points under this subdivision shall be determined as follows:

Nursing Facility's Annual RN/LPN Turnover Rate	Quality Points Awarded
Less than or equal to 26.1%	**1**
Greater than 26.1% and less than 71.4%	**Proportional quality points awarded as follows: 1 – [(26.1% – facility's annual RN/LPN turnover rate) × (-2.207506)]**
Equal to or greater than 71.4%	**0**

Facilities that are a new operation and did not have RNs/LPNs for the entire calendar year preceding March 31, 2013, or each March 31 thereafter, shall be awarded the statewide average quality points for this measure. Facilities that did not submit a Schedule X as of March 31 shall receive zero (0) quality points for this measure.

(6) CNA turnover rate. The office or its contractor shall determine each nursing facility's CNA turnover rate using data from its Schedule X. Each nursing facility shall be awarded no more than two (2) quality points based on the facility's CNA turnover rate. Quality points shall be determined using each nursing facility's most recently completed Schedule X as of March 31, 2013, and each March 31 thereafter. Each nursing facility's quality points under this subdivision shall be determined as follows:

Nursing Facility Annual CNA Turnover Rates	Quality Points Awarded
Less than or equal to 39.4%	**2**
Greater than 39.4% and less than 96.2%	**Proportional quality points awarded as follows: 2 – [39.4% – facility's annual CNA turnover rate) × (-3.521127)]**
Equal to or greater than 96.2%	**0**

Facilities that are a new operation and did not have a CNA for the entire calendar year preceding March 31, 2013, or each March 31 thereafter, shall be awarded the statewide average quality points for this measure. Facilities that did not submit a Schedule X as of March 31 shall receive zero (0) quality points for this measure.

(7) Administrator turnover. The office or its contractor shall determine each nursing facility's administrator turnover rate using data from its Schedule X. The nursing facility administrator turnover rate shall be based on the number of nursing home administrators employed or designated by the facility during the most recent five (5) year period. A nursing facility administrator hired on a temporary basis due to a documented medical or other temporary leave of absence shall not be counted in cases where the previous administrator is reasonably expected to return to the position and whose employment or designation as facility administrator is not terminated. Any such leave of absence shall be documented to the satisfaction of the office. Each nursing facility shall be awarded not more than three (3) quality points based on the facility's administrator turnover rate. Quality points shall be determined using each nursing facility's most recently completed Schedule X as of March 31, 2013, and each March 31 thereafter. Each nursing facility's quality points under this subdivision shall be determined as follows:

Number of Administrators Employed Within the Lasts *[sic]* Five (5) Years	Quality Points Awarded
6 or more	**0**
5	**1**
4	**2**
3 or fewer	**3**

Facilities that did not have a facility administrator employed or designated for the previous five (5)

years shall be awarded the statewide average quality points for this measure. Facilities that did not submit a Schedule X as of March 31 shall receive zero (0) quality points for this measure.

(8) Director of nursing (DON) turnover. The office or its contractor shall determine each nursing facility's DON turnover rate using data from its Schedule X. The nursing facility DON turnover rate shall be based on the number of DONs employed or designated by the facility during the most recent five (5) year period. A nursing facility DON hired on a temporary basis due to a documented medical or other temporary leave of absence shall not be counted in cases where the previous DON is reasonably expected to return to the position and whose employment or designation as facility DON is not terminated. Any such leave of absence shall be documented to the satisfaction of the office. Each nursing facility shall be awarded no more than three (3) quality points based on the number of DONs employed or designated by the facility during the most recent five (5) year period. Quality points shall be determined using each nursing facility's most recently completed Schedule X as of March 31, 2013, and each March 31 thereafter. Each nursing facility's quality points under this subdivision shall be determined as follows:

Number of DONs Employed Within the Lasts *[sic]* Five (5) Years	Quality Points Awarded
6 or more	0
5	1
4	2
3 or fewer	3

Facilities that did not have a facility DON employed or designated for the previous five (5) years shall be awarded the statewide average quality points for this measure. Facilities that did not submit a Schedule X as of March 31 shall receive zero (0) quality points for this measure.

~~(o) The capital component rate add-on described under subsection (n) shall be exempt from the capital component overall rate ceiling as determined under section 9(c)(4) of this rule.~~

~~(p) The capital component rate add-on described under subsection (n) shall be exempt from the maximum allowable increase as determined under section 23 of this rule.~~

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-7; filed Aug 12, 1998, 2:27 p.m.: 22 IR 74, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2243; readopted filed Jun 27, 2001, 9:40 a.m.:24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2468; filed Oct 10, 2002, 10:47 a.m.: 26 IR 712; errata filed Feb 27, 2003, 11:33 a.m.: 26 IR 2375; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3873; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2978; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Apr 3, 2009, 1:44 p.m.: 20090429-IR-405080602FRA; filed Nov 12, 2009, 4:01 p.m.: 20091209-IR-405090215FRA; filed Nov 1, 2010, 11:37 a.m.: 20101201-IR-405100183FRA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA)

SECTION 10. 405 IAC 1-14.6-9 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-9 Rate components; rate limitations; profit add-on

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-13-6

Sec. 9. (a) The Medicaid reimbursement system is based on recognition of the provider's allowable costs for the direct care, therapy, indirect care, administrative, and capital components, plus a potential profit add-on payment as defined below. The direct care, therapy, indirect care, administrative, and capital rate components are calculated as follows:

(1) The direct care component is equal to the provider's normalized allowable per patient day direct care costs times the facility-average CMI for Medicaid residents, plus the allowed profit add-on payment as determined by the methodology in subsection (b).

(2) The therapy component is equal to the provider's allowable Medicaid per patient day direct therapy costs.

~~(1)~~ **(3)** The indirect care and capital components are equal to the provider's allowable per patient day costs for each component, plus the allowed profit add-on payment as determined by the methodology in subsection (b).

~~(2) The therapy component is equal to the provider's allowable Medicaid per patient day direct therapy costs.~~

~~(3) The direct care component is equal to the provider's normalized allowable per patient day direct care costs times the facility-average CMI for Medicaid residents, plus the allowed profit add-on payment as determined~~

~~by the methodology in subsection (b).~~

(4) The administrative component shall be equal to one hundred percent (100%) of the average allowable cost of the median patient day.

(b) The profit add-on payment will be calculated as follows:

(1) For nursing facilities designated by the office as children's nursing facilities, the allowed direct care component profit add-on is equal to the profit add-on percentage contained in Table 1, times the difference (if greater than zero (0)) between:

(A) the normalized average allowable cost of the median patient day for direct care costs times the facility average CMI for Medicaid residents times the profit ceiling percentage contained in Table 1; minus

(B) the provider's normalized allowable per patient day costs times the facility average CMI for Medicaid residents.

Table 1				
Children's Nursing Facilities				
	Direct Care Profit Add-on Percentage		Direct Care Profit Ceiling Percentage	
Effective Date	July 1, 2003, through June 30, ~~2011~~ **2014**	July 1, ~~2011,~~ **2014,** and after	July 1, 2003, through June 30, ~~2011~~ **2014**	July 1, ~~2011,~~ **2014,** and after
Percentage	30%	52%	110%	105%

(2) For nursing facilities that are not designated by the office as children's nursing facilities, the tentative direct care component profit add-on payment is equal to the profit add-on percentage contained in Table 2, times the difference (if greater than zero (0)) between:

(A) the normalized average allowable cost of the median patient day for direct care costs times the facility average CMI for Medicaid residents times the profit ceiling percentage contained in Table 2; minus

(B) the provider's normalized allowable per patient day costs times the facility average CMI for Medicaid residents.

Table 2				
Non-Children's Nursing Facilities				
	Direct Care Profit Add-on Percentage		Direct Care Profit Ceiling Percentage	
Effective Date	July 1, 2003, through June 30, ~~2011~~ **2014**	July 1, ~~2011,~~ **2014,** and after	July 1, 2003, through June 30, ~~2011~~ **2014**	July 1, ~~2011,~~ **2014,** and after
Percentage	30%	0%	110%	105%

(C) For nursing facilities not designated by the office as children's nursing facilities, the allowed direct care component profit add-on payment is equal to the facility's tentative direct care component profit add-on payment times the applicable percentage contained in Table 3, based on the facility's nursing home report card score as determined by the office or its contractor using the latest published data as of the end of each state fiscal year, **or t**he facility's total quality score, as applicable.

~~Table 3 – Allowed Direct Care Profit Add-On Percentage~~		
~~Nursing Home Report Card Score~~	~~Effective Dates~~	
	~~First Full Calendar Quarter through Fourth Full Calendar Quarter Following Rule Effective Date~~	~~Fifth Full Calendar Quarter Following Rule Effective Date and Thereafter~~
~~0 – 82~~	~~100%~~	~~100%~~
~~83 – 357~~	~~100% - ((Nursing Home Report Card Score – 82) × 0.36232%)~~	~~N/A~~
~~358 and greater~~	~~0%~~	~~N/A~~
~~83 – 279~~	~~N/A~~	~~100% - ((Nursing Home Report Card Score - 82) × 0.50505%)~~
~~280 and greater~~	~~N/A~~	~~0%~~

Table 3	
Allowed Profit Add-On Percentage	
Nursing Home Report Card Score for Period 7/1/2012 through 6/30/2013	
0 – 82	**100%**
83 – 279	**100% - ((Nursing Home Report Card Score - 82) × 0.50505%)**
280 and greater	**0%**

Total Quality Score for Period 7/1/2013 through 6/30/2014	
84 - 100	**100%**
19 - 83	**100% + ((Total Quality Score - 84) / 66)**
18 and below	**0%**

(D) In no event shall the allowed direct care profit add-on payment exceed ten percent (10%) of the average allowable cost of the median patient day.

(3) The tentative indirect care component profit add-on payment is equal to the profit add-on percentage contained in Table 4, times the difference (if greater than zero (0)) between:

(A) the average allowable cost of the median patient day times the profit ceiling percentage contained in Table 4; minus

(B) a provider's allowable per patient day cost.

Table 4				
	Indirect Care Profit Add-on Percentage		Indirect Care Profit Ceiling Percentage	
Effective Date	July 1, 2003, through June 30, ~~2011~~ **2014**	July 1, ~~2011,~~ **2014,** and after	July 1, 2003, through June 30, ~~2011~~ **2014**	July 1, ~~2011,~~ **2014,** and after
Percentage	60%	52%	105%	100%

(C) The allowed indirect care component profit add-on payment is equal to the facility's tentative indirect care component profit add-on payment times the applicable percentage contained in ~~Table 5,~~ **Table 3,** based on the facility's nursing home report card score as determined by the office or its contractor using the latest published data as of the end of each state fiscal year, **or the facility's total quality score as applicable.**

~~Table 5 – Allowed Indirect Care Profit Add-On Percentage~~		
~~Nursing Home Report Card Score~~	~~Effective Dates~~	
	~~First Full Calendar Quarter through Fourth Full Calendar Quarter Following Rule Effective Date~~	~~Fifth Full Calendar Quarter Following Rule Effective Date and Thereafter~~
~~0 – 82~~	~~100%~~	~~100%~~
~~83 – 357~~	~~100% - ((Nursing Home Report Card Score – 82) × 0.36232%)~~	~~N/A~~
~~358 and greater~~	~~0%~~	~~N/A~~
~~83 – 279~~	~~N/A~~	~~100% - ((Nursing Home Report Card Score - 82) × 0.50505%)~~
~~280 and greater~~	~~N/A~~	~~0%~~

(4) The tentative capital component profit add-on payment is equal to sixty percent (60%) times the difference (if greater than zero (0)) between:

(A) the average allowable cost of the median patient day times the profit ceiling percentage contained in ~~Table 6;~~ **Table 5;** minus

(B) a provider's allowable per patient day cost.

~~Table 6~~ **Table 5**		
Capital Component Profit Ceiling Percentage		
Effective Date	July 1, 2003, through June 30, ~~2011~~ **2014**	July 1, ~~2011,~~ **2014,** and after
Percentage	100%	80%

(C) The allowed capital component profit add-on payment is equal to the facility's tentative capital component profit add-on payment times the applicable percentage contained in ~~Table 7,~~ **Table 3,** based on the facility's nursing home report card score as determined by the office or its contractor using the latest published data as of the end of each state fiscal year, **or the facility's total quality score, as applicable.**

~~Table 7 – Allowed Capital Profit Add-On Percentage~~		
~~Nursing Home Report Card Score~~	~~Effective Dates~~	
	~~First Full Calendar Quarter through Fourth Full Calendar Quarter Following Rule Effective Date~~	~~Fifth Full Calendar Quarter Following Rule Effective Date and Thereafter~~
~~0 – 82~~	~~100%~~	~~100%~~
~~83 – 357~~	~~100% - ((Nursing Home Report Card Score – 82) × 0.36232%)~~	~~N/A~~
~~358 and greater~~	~~0%~~	~~N/A~~

~~83 – 279~~	~~N/A~~	~~100% - ((Nursing Home Report Card Score - 82) × 0.50505%)~~
~~280 and greater~~	~~N/A~~	~~0%~~

(5) The therapy component profit add-on is equal to zero (0).

(c) Notwithstanding subsections (a) and (b), in no instance shall a rate component exceed the overall rate ceiling defined as follows:

(1) The normalized average allowable cost of the median patient day for direct care costs times the facility-average CMI for Medicaid residents times the overall rate ceiling percentage in ~~Table 8.~~ **Table 6.**

~~Table 8~~ **Table 6**		
Direct Care Component Overall Rate Ceiling Percentage		
Effective Date	July 1, 2003, through June 30, ~~2011~~ **2014**	July 1, ~~2011,~~ **2014,** and after
Percentage	120%	110%

(2) The average allowable cost of the median patient day for indirect care costs times the overall rate ceiling percentage in ~~Table 9.~~ **Table 7.**

~~Table 9~~ **Table 7**		
Indirect Care Component Overall Rate Ceiling Percentage		
Effective Date	July 1, 2003, through June 30, ~~2011~~ **2014**	July 1, ~~2011,~~ **2014,** and after
Percentage	115%	100%

(3) The average allowable cost of the median patient day for capital-related costs times the overall rate ceiling percentage in ~~Table 10.~~ **Table 8.**

~~Table 10~~ **Table 8**		
Capital Component Overall Rate Ceiling Percentage		
Effective Date	July 1, 2003, through June 30, ~~2011~~ **2014**	July 1, ~~2011,~~ **2014,** and after
Percentage	100%	80%

(4) For the therapy component, no overall rate component limit shall apply.

(d) In order to determine the normalized allowable direct care costs from each facility's Financial Report for Nursing Facilities, the office or its contractor shall determine each facility's CMI for all residents on a time-weighted basis.

(e) The office shall publish guidelines for use in determining the time-weighted CMI. These guidelines:

(1) shall be published as a provider bulletin; and

(2) may be updated by the office as needed.

Any such updates shall be made effective no earlier than permitted under IC 12-15-13-6(a).

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-9; filed Aug 12, 1998, 2:27 p.m.: 22 IR 75, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2244; readopted filed Jun 27, 2001, 9:40 a.m.:24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2470; filed Oct 10, 2002, 10:47 a.m.: 26 IR 714; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3874; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2980; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 12, 2009, 4:01 p.m.: 20091209-IR-405090215FRA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA)

SECTION 11. 405 IAC 1-14.6-10 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-10 Computation of rate; allowable costs; review of cost reasonableness

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 10. (a) Costs and revenues, excluding non-Medicaid routine revenue, shall be reported as required on the financial report forms. Allowable patient care costs shall be clearly identified.

(b) The provider shall report as patient care costs only costs that have been incurred in the providing of patient care services. The provider shall certify on all financial reports that costs not related to patient care have been

separately identified on the financial report.

(c) In determining reasonableness of costs, the office may compare line items, cost centers, or total costs of providers throughout the state. The office or its contractors may request satisfactory documentation from providers whose costs do not appear to be accurate or allowable.

(d) Indiana state taxes, including local taxes, shall be considered an allowable cost. Personal or federal income taxes are not considered allowable costs.

(e) The following costs are not considered allowable costs and shall not be included in the established rate:

(1) All over-the-counter, legend, and nonlegend drugs.
(2) Cost of replacement hearing aids and eyeglasses.
(3) All costs associated with pastoral care.
(4) All costs associated with resident and family gifts, including, but not limited to, flowers, Bibles, and memory books.
(5) All costs associated with collection fees.
(6) All costs, fees, and dues associated with lobbying activities.
(7) All costs of acquisitions, such as the purchase of corporate stock as an investment or purchases of new facilities.
(8) All costs associated with barber and beauty shop activities.
(9) All costs associated with marketing.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-10; filed Aug 12, 1998, 2:27 p.m.: 22 IR 76, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2245; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA)

SECTION 12. 405 IAC 1-14.6-11 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-11 Allowable costs; services provided by parties related to the provider

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 11. (a) **For facilities other than nonstate government owned nursing facilities,** costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control ~~may~~ **must** be included in the allowable cost in the unit of service of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased ~~elsewhere in~~ **as** an arm's-length transaction **in an open competitive market.**

(b) For nonstate government owned (NSGO) nursing facilities, costs applicable to services, facilities, and supplies furnished to the provider by organizations related by common ownership or control to either the current NSGO provider, or any former provider or related entity that currently serves as the management company or entity in a similar decision making capacity for the NSGO provider, must be included in the allowable cost of the NSGO provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased as an arm's-length transaction in an open competitive market.

~~(b)~~ **(c)** Common ownership exists when an individual, individuals, or any legal entity possesses ownership or equity of at least five percent (5%) in the provider as well as the institution or organization serving the provider. An individual is considered to own the interest of immediate family for the determination of percentage of ownership. The following persons are considered immediate family:

(1) Husband and wife.
(2) Natural parent, child, and sibling.
(3) Adopted child and adoptive parent.
(4) Stepparent, stepchild, stepsister, and stepbrother.
(5) Father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, ~~and~~ daughter-in-law, **stepson-in-law,**

and stepdaughter-in-law.
(6) Grandparent and grandchild.

~~(c)~~ **(d)** Control exists where an individual or an organization has the power, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised. A general partner is considered to control an entity.

~~(d)~~ **(e)** Transactions between related parties are not considered to have arisen through arm's-length negotiations. Costs applicable to services, facilities, and supplies furnished to a provider by related parties shall not exceed the lower of the cost to the related party, or the price of comparable services, facilities, or supplies purchased ~~elsewhere.~~ **as an arm's-length transaction in an open competitive market.** An exception to this subsection may be granted by the office if requested in writing by the provider before the annual rate review effective date to which the exception is to apply. The provider's request shall include a comprehensive representation that every condition in subsection ~~(c)~~ **(f)** has been met. This representation shall include, but not be limited to, the percentage of business the provider transacts with related and nonrelated parties based upon revenue. When requested by the office, **the provider shall submit** documentation, **such as invoices, standard charge master listings, and remittances,** to substantiate the provider's charges for services, facilities, or supplies to related and nonrelated parties. ~~such as invoices, standard charge master listings, and remittances, must be submitted.~~

~~(e)~~ **(f)** The office shall grant an exception when a related organization meets all of the following conditions:
(1) The supplying organization is a bona fide separate organization **whose services, facilities, and supplies are made available to the public in an open competitive market.**
(2) A sufficient part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier in common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization. **Transactions with residents of nursing facilities that are owned, operated, or managed by the provider or organizations related to the provider or any former provider or related entity that currently serves as the management company or entity in a similar decision making capacity for a NSGO provider shall not be considered an arm's-length business activity transacted in an open competitive market.**
(3) The services, supplies, or facilities are those that commonly are obtained by institutions, such as the provider, from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions.
(4) **For facilities other than NSGO nursing facilities, the organization actually furnishes such services, facilities, or supplies to other nonrelated party organizations, and** the charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.
(5) For NSGO nursing facilities, the organization actually furnishes such services, facilities or supplies to organizations that are not related to the NSGO provider or any former provider or related entity that currently serves as the management company or entity in a similar decision making capacity for the NSGO provider. The charge to the provider shall be:
(A) in line with the charge for such services, facilities, or supplies in the open market; and
(B) not more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

(g) The related-party exception shall be granted for any period of time, up to the maximum period of two (2) years.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-11; filed Aug 12, 1998, 2:27 p.m.: 22 IR 76, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2245; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA)

SECTION 13. 405 IAC 1-14.6-12 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-12 Allowable costs; fair rental value allowance

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 12. **(a)** Providers shall be reimbursed for the use of allowable patient-related facilities and equipment, regardless of whether they are owned or leased, by means of a fair rental value allowance. The fair rental value allowance shall be in lieu of the costs of all depreciation, interest, lease, rent, or other consideration paid for the use of property, ~~This~~ **except that rental costs for low air loss mattresses, pressure support surfaces, and oxygen concentrators shall be reimbursed in the direct care component. The fair rental value allowance** includes all central office facilities and equipment whose patient care-related depreciation, interest, or lease expense is appropriately allocated to the facility.

~~(1)~~ **(b)** The fair rental value allowance is calculated ~~by determining,~~ **as follows:**

(1) Determine, on a per bed basis, the historical cost of allowable patient-related property for facilities that are not acquired through an operating lease arrangement, including:

(A) land, building, improvements, vehicles, and equipment; and

(B) costs;

required to be capitalized in accordance with generally accepted accounting principles. Land, buildings, and improvements shall be adjusted for changes in valuation by inflating the reported allowable patient-related historical cost of property from the later of July 1, 1976, or the date of facility acquisition to the present based on the change in the R. S. Means Construction Index.

(2) The inflation-adjusted historical cost of property per bed as determined ~~above~~ **in subdivision (1)** is arrayed to arrive at the average historical cost of property of the median bed.

(3) The average historical cost of property of the median bed as determined ~~above~~ **in subdivision (2)** is extended times the number of beds for each facility that are used to provide nursing facility services to arrive at the fair rental value amount.

(4) The fair rental value amount is extended by a rental rate to arrive at the fair rental allowance. The rental rate shall be a simple average of the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), in effect on the first day of the month that the index is published for each of the twelve (12) months immediately preceding the rate effective date as determined in section 6(a) of this rule. The rental rate shall be updated quarterly on January 1, April 1, July 1, and October 1.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-12; filed Aug 12, 1998, 2:27 p.m.: 22 IR 77, eff Oct 1, 1998; filed Sep 1, 2000, 2:10 p.m.: 24 IR 21; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:47 a.m.: 26 IR 715; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA)

SECTION 14. 405 IAC 1-14.6-14 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-14 Property; basis; historical cost; mandatory record keeping; valuation

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 14. (a) The basis used in computing the average historical cost of property of the median bed shall be the historical cost of all assets used to deliver patient-related services that meet the following conditions:

(1) The assets are in use.

(2) The assets are identifiable to patient care.

(3) The assets are available for physical inspection.

(4) The assets are recorded in provider records.

If an asset does not meet all of the requirements prescribed in this section, the cost shall not be included in computing the average historical cost of property of the median bed.

(b) The provider shall maintain detailed property schedules to provide a permanent record of all historical costs and balances of facilities and equipment. Summaries of such schedules shall be submitted with each annual financial report, and the complete schedule shall be submitted to the office upon request.

(c) Assets used in computing the average historical cost of property of the median bed shall include only items currently used in providing services customarily provided to patients.

(d) When an asset is acquired by trading one (1) asset for another, or a betterment or improvement is acquired, the cost of the newly acquired asset, betterment, or improvement shall be added to the appropriate property category. All of the historical cost of the traded asset or replaced betterment or improvement shall be

removed from the property category in which it was included.

(e) If a single asset or collection of like assets acquired in quantity, including permanent betterment or improvements, has at the time of acquisition an estimated useful life of at least three (3) years and a historical cost of at least ~~five hundred~~ **one thousand** dollars ~~($500),~~ **($1,000),** the cost shall be capitalized and included in the property basis for the approved useful life of the asset. Items that do not qualify under this subsection shall be expensed in the year acquired.

(f) The property basis of donated assets, except for donations between providers or related parties, shall be the fair market value defined as the price a prudent buyer would pay a seller in an arm's-length sale, or, if over two thousand dollars ($2,000), the appraised value, whichever is lower. An asset is considered donated when the provider acquires the asset without making any payment for it in the form of cash, property, or services. If the provider and the donor are related parties, the net book value of the asset to the donor shall be the basis, not to exceed fair market value. Cash donations shall be treated as revenue items and not as offsets to expense accounts.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-14; filed Aug 12, 1998, 2:27 p.m.: 22 IR 78, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA)

SECTION 15. 405 IAC 1-14.6-18 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-18 Allowable costs; calculation of allowable owner or related party compensation; wages; salaries; fees

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 18. (a) Compensation for:
(1) **an** owner, **a** related party, management, general line personnel, and consultants who perform management functions; or
(2) any individual or entity rendering services above the department head level;
shall be subject to the annual limitations described in this section. All compensation received by the parties as described in this subsection shall be reported and separately identified on the financial report form even though such payment may exceed the limitations. This compensation is allowed to cover costs for all administrative, policymaking, decision making, and other management functions above the department head level. Beginning effective July 1, 2003, through June 30, ~~2011,~~ **2014,** compensation subject to this limitation includes wages, salaries, and fees for **the** owner, management, contractors, and consultants who actually perform management functions as well as any other individual or entity performing such tasks. Beginning effective July 1, ~~2011,~~ **2014,** and thereafter, wages, salaries, and fees paid for **the** owner, administrator, assistant administrator, management, contractors, and consultants who actually perform management functions as well as any other individual or entity performing such tasks are subject to this limitation.

(b) Beginning effective July 1, 2003, through June 30, ~~2011,~~ **2014,** the maximum allowable amount for owner, related party, and management compensation shall be the average allowable cost of the median patient day for owner, related party, and management compensation subject to this limitation as defined in subjection (a). The average allowable cost of the median patient day shall be updated four (4) times per year effective January 1, April 1, July 1, and October 1.

(c) Beginning effective July 1, ~~2011,~~ **2014,** the maximum amount of owner, related party, and management compensation for the parties identified in subsection (a) shall be the lesser of the amount:
(1) under subsection (d), as updated by the office on July 1 of each year based on the average rate of change of the most recent twelve (12) quarters of the Gross National Product Implicit Price Deflator; or
(2) of patient-related wages, salaries, or fees actually paid or withdrawn that were properly reported to the federal Internal Revenue Service as wages, salaries, fringe benefits, or fees.
If liabilities are established, they shall be paid within seventy-five (75) days after the end of the accounting period or the costs shall be disallowed.

(d) The owner, related party, and management compensation limitation per operation effective July 1, 1995, shall be as follows:

Owner and Management Compensation	
Beds	Allowance
10	$21,542
20	$28,741
30	$35,915
40	$43,081
50	$50,281
60	$54,590
70	$58,904
80	$63,211
90	$67,507
100	$71,818
110	$77,594
120	$83,330
130	$89,103
140	$94,822
150	$100,578
160	$106,311
170	$112,068
180	$117,807
190	$123,562
200	$129,298
200 and over	$129,298 + $262/bed over 200

This subsection applies to each provider of a Medicaid-certified operation. The unused portions of the allowance for one (1) operation shall not be carried over to other operations.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-18; filed Aug 12, 1998, 2:27 p.m.: 22 IR 80, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2982; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 12, 2009, 4:01 p.m.: 20091209-IR-405090215FRA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA)

SECTION 16. 405 IAC 1-14.6-22 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-22 Administrative reconsideration; appeal

Authority: IC 12-15-1-10; IC 12-15-21-3
Affected: IC 4-21.5-3; IC 12-13-7-3; IC 12-15

Sec. 22. (a) The Medicaid rate-setting contractor shall notify each provider of the provider's rate after such rate has been computed. If the provider disagrees with the rate ~~or allowable cost determinations,~~ the provider ~~must~~ **may** request an administrative reconsideration by the Medicaid rate-setting contractor. Such reconsideration request shall be in writing and shall contain specific issues to be reconsidered and the rationale for the provider's position. **The provider must request administrative reconsideration before filing an appeal. Only issues raised by the provider during the administrative reconsideration may be subsequently raised in an appeal.** The request shall be signed by the provider or the authorized representative of the provider and must be received by the contractor ~~within~~ **not later than** forty-five (45) days after release of the rate as computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid rate-setting contractor shall evaluate the data. After review, the Medicaid rate-setting contractor may amend the rate, amend the challenged procedure ~~or allowable cost determination,~~ or affirm the original decision. The Medicaid rate-setting contractor shall thereafter notify the provider of its final decision in writing, ~~within~~ **not later than** forty-five (45) days ~~of~~ **from** the Medicaid rate-setting contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the rate-setting contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies as set out in subsection (d).

(b) If the provider disagrees with ~~a rate redetermination~~ **the preliminary recalculated Medicaid rate** resulting from a financial audit adjustment or reportable condition ~~affecting a rate,~~ the provider ~~must~~ **may** request an administrative reconsideration from the Medicaid ~~financial~~ audit contractor. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. **The provider must request administrative reconsideration before filing an appeal. Only issues raised by the provider during the administrative reconsideration may be subsequently raised in an appeal.** The request shall be signed by the provider or authorized representative of the provider and must be received by the Medicaid audit contractor ~~within~~ **not later than** forty-five (45) days after release of the **preliminary recalculated Medicaid** rate computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid audit contractor shall evaluate the data. After review, the Medicaid audit contractor may amend the audit adjustment or reportable condition or affirm the original adjustment **or reportable condition.** The Medicaid audit contractor shall thereafter notify the provider of its final decision in writing ~~within~~ **not later than** forty-five (45) days ~~of~~ **from** the Medicaid audit contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the audit contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (d).

(c) If the provider disagrees with a rate redetermination resulting from a recalculation of its CMI due to an MDS audit affecting the established Medicaid rate, the provider ~~must~~ **may** request an administrative reconsideration from the ~~MDS audit~~ **Medicaid rate-setting** contractor. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. **The provider must request administrative reconsideration before filing an appeal. Only issues raised by the provider during the administrative reconsideration may be subsequently raised in an appeal.** The request shall be signed by the provider or authorized representative of the provider and must be received by the ~~MDS audit~~ **Medicaid rate-setting** contractor ~~within~~ **not later than** forty-five (45) days after release of the rate computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the ~~MDS audit~~ **Medicaid rate-setting** contractor **shall forward the administrative reconsideration to the MDS audit contractor who** shall evaluate the data. After review, the MDS audit contractor may amend the audit adjustment or affirm the original adjustment. The MDS audit contractor shall thereafter notify the provider of its final decision in writing ~~within~~ **not later than** forty-five (45) days ~~of~~ **from** the ~~MDS audit~~ **Medicaid rate-setting** contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the ~~audit~~ **Medicaid rate-setting** contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (d).

(d) After completion of the reconsideration procedure under subsection (a), (b), or (c), the provider may initiate an appeal under IC 4-21.5-3. **The request for an appeal must be signed by the nursing facility provider.**

(e) The office may take action to implement Medicaid rates without awaiting the outcome of the administrative process, in accordance with section 1(d) of this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-22; filed Aug 12, 1998, 2:27 p.m.: 22 IR 81, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2247; errata filed Jul 28, 1999, 3:10 p.m.: 22 IR 3937; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:47 a.m.: 26 IR 716; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3876; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA)

SECTION 17. 405 IAC 1-14.6-24 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-24 Nursing facility quality assessment

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 4-21.5-3; IC 12-13-7-3; IC 12-15-21-3; IC 16-21; IC 16-28-15-2; IC 16-28-15-7; IC 23-2-4

Sec. 24. (a) Effective ~~August 1, 2003~~ **from July 1, 2011,** through ~~June~~ **September** 30, 2011, the office shall collect a quality assessment from each nursing facility licensed under IC 16-28 as a comprehensive care facility based on the most recently completed annual financial report or quality assessment data collection form, as follows:

(1) Privately owned or operated nursing facilities with total annual nursing facility census days fewer than seventy thousand (70,000), ~~ten~~ **fourteen** dollars ~~($10)~~ **and seventy cents ($14.70)** per non-Medicare day.

(2) Privately owned or operated nursing facilities with total annual nursing facility census days equal to or greater than seventy thousand (70,000), ~~two~~ **three** dollars and ~~fifty~~ **sixty-eight** cents ~~($2.50)~~ **($3.68)** per non-Medicare day.

(3) Nonstate government owned or operated nursing facilities that became nonstate government owned or operated before July 1, 2003, ~~two~~ **three** dollars and ~~fifty~~ **sixty-eight** cents ~~($2.50)~~ **($3.68)** per non-Medicare day.

(4) Nonstate government owned or operated nursing facilities that became nonstate government owned or operated on or after July 1, 2003, ~~ten~~ **fourteen** dollars ~~($10)~~ **and seventy cents ($14.70)** per non-Medicare day.

(b) Effective from October 1, 2011, through June 30, 2014, the office shall collect a quality assessment from each nursing facility licensed under IC 16-28 as a comprehensive care facility based on the most recently completed annual financial report or quality assessment data collection form, as follows:

(1) Privately owned or operated nursing facilities with total annual nursing facility census days fewer than seventy thousand (70,000), sixteen dollars ($16) per non-Medicare day.

(2) Privately owned or operated nursing facilities with total annual nursing facility census days equal to or greater than seventy thousand (70,000), four dollars ($4) per non-Medicare day.

(3) Nonstate government owned or operated nursing facilities that became nonstate government owned or operated before July 1, 2003, four dollars ($4) per non-Medicare day.

(4) Nonstate government owned or operated nursing facilities that became nonstate government owned or operated on or after July 1, 2003, sixteen dollars ($16) per non-Medicare day.

~~(b)~~ **(c) Under IC 16-28-15-7(2),** the following nursing facilities shall be exempt from the quality assessment described in subsection (a):

(1) A continuing care retirement community ~~registered with the securities commissioner of the office of the secretary of state under IC 23-2-4 that satisfies all provisions of P.L.182-2009(ss), SECTION 486(f)(1).~~ **that meets one of the following:**

(A) A continuing care retirement community that was registered with the securities commissioner as a continuing care retirement community on January 1, 2007.

(B) A continuing care retirement community that for the entire period from January 1, 2007, through June 30, 2009, operated independent living units, at least twenty-five percent (25%) of which are provided under contracts that require the payment of a minimum entrance fee of at least twenty-five thousand dollars ($25,000).

(C) An organization registered under IC 23-2-4 before July 1, 2009, that provides housing in an independent living unit for a religious order.

(D) A continuing care retirement community that meets the definition set forth in IC 16-28-15-2.

(2) A hospital-based nursing facility licensed under IC 16-21.

(3) The Indiana Veterans' Home.

~~(c)~~ **(d)** For nursing facilities certified for participation in the Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), the quality assessment shall be an allowable cost for cost reporting and auditing purposes. The quality assessment shall be included in Medicaid reimbursement as an add-on to the Medicaid rate. The add-on is determined by dividing the product of the assessment rate times total non-Medicare patient days by total patient days from the most recently completed desk reviewed annual financial report.

~~(d)~~ **(e)** For nursing facilities that are not certified for participation in the Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), the facility shall remit the quality assessment to the state of Indiana within ten (10) days after the due date. If a nursing facility fails to pay the quality assessment under this subsection within ten (10) days after the date the payment is due, the nursing facility shall pay interest on the quality assessment at the same rate as determined under IC 12-15-21-3(6)(A).

~~(e)~~ **(f)** The office or its contractor shall notify each nursing facility of the amount of the facility's assessment after the amount of the assessment has been computed. If the facility disagrees with the computation of the assessment, the facility shall request an administrative reconsideration by the Medicaid rate-setting contractor. The reconsideration request shall be as follows:

(1) In writing.

(2) Contain the following:

(A) Specific issues to be reconsidered.

(B) The rationale for the facility's position.

(3) Signed by the authorized representative of the facility and must be received by the contractor ~~within~~ **not later than** forty-five (45) days after the notice of the assessment is mailed.

Upon receipt of the request for reconsideration, the Medicaid rate-setting contractor shall evaluate the data. After review, the Medicaid rate-setting contractor may amend the assessment or affirm the original decision. The Medicaid rate-setting contractor shall thereafter notify the facility of its final decision in writing, within forty-five (45) days of the Medicaid rate-setting contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the rate-setting contractor to the facility's reconsideration request, the request shall be deemed denied and the provider may initiate an appeal under IC 4-21.5-3.

~~(f)~~ **(g)** The assessment shall be calculated on an annual basis with equal monthly amounts due on or before the tenth day of each calendar month.

~~(g)~~ **(h)** A facility may file a request to pay the quality assessment on an installment plan. The request shall be as follows:

(1) In writing setting forth the facility's rationale for the request.

(2) Submitted to the office or its designee.

An installment plan established under this section shall not exceed a period of six (6) months from the date of execution of the agreement. The agreement shall set forth the amount of the assessment that shall be paid in installments and include provisions for the collection of interest. The interest shall not exceed the percentage set out in IC 12-15-21-3(6)(A).

~~(h)~~ **(i)** A facility that fails to pay the quality assessment due under this section within ten (10) days after the date the payment is due shall pay interest on the quality assessment at the same rate as determined under IC 12-15-21-3(6)(A).

~~(i)~~ **(j)** The office ~~may withhold Medicaid payments to a facility that fails to pay an assessment within thirty (30) days after the due date. The amount withheld may not exceed the amount of the assessment and any interest due under subsection (h).~~ **shall offset the collection of the assessment fee for a facility as follows:**

(1) Against a Medicaid payment to the facility.

(2) Against a Medicaid payment to another health facility that is related to the facility through common ownership or control.

(3) In another manner determined by the office.

~~(j)~~ **(k) If a facility:**

(1) fails to submit patient day information requested by the office to calculate the quality assessment fee; or

(2) fails to pay the quality assessment fee;

not later than one hundred twenty (120) days after **the patient day information is requested, or** payment of the quality assessment ~~was~~ **is** due, the office shall report each facility ~~that has failed to pay the quality assessment by the due date~~ to the state department of health to initiate license revocation proceedings **in accordance with IC 16-28-15-12.**

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-24; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2983; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 12, 2009, 4:01 p.m.: 20091209-IR-405090215FRA; filed Nov 1, 2010, 11:45 a.m.: 20101201-IR-405100065FRA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA)

SECTION 18. THE FOLLOWING ARE REPEALED: 405 IAC 1-14.6-23; 405 IAC 1-14.6-25.

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